

X and Why?



ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

ANTHC
Diabetes
Program

All things Alaska SDPI Data

Welcome to the inaugural issue of the ANTHC Diabetes Registry team's newsletter!

The ANTHC Diabetes Registry team will be releasing two newsletters a year that showcase Alaska Tribal Health System data topics.

In this very first issue we are covering four topics: A review of the diabetes diagnostic criteria, an interview with Dr. Cindy Schraer, the founder of the ANTHC Diabetes Registry, a highlight of the Patient Handout tab/feature in the Special Diabetes Program for Indians (SDPI) dashboard, and ideas for a fun activity using data in your community.

Do you have an Alaska tribal health data topic you'd like to see in this newsletter? Let us know! Do you have a data project you'd like to let your fellow SDPI coordinators know about? Awesome! We'd love to feature you and what you're working on! Our contact info is on the back page of this newsletter, just shoot us an email.

Did you know?

Depression screening went from 21% to 67% in 15 years!! Great job screening for depression, SDPI teams!

"Things get done only if the data we gather can inform and inspire those in a position to make [a] difference."

— Mike Schmoker

Word of the month

Data: Data is information such as facts and numbers used to analyze something or make decisions.

Source: vocabulary.com;
Accessed 3/9/2022.



The Diabetes Dashboard can do What?!!

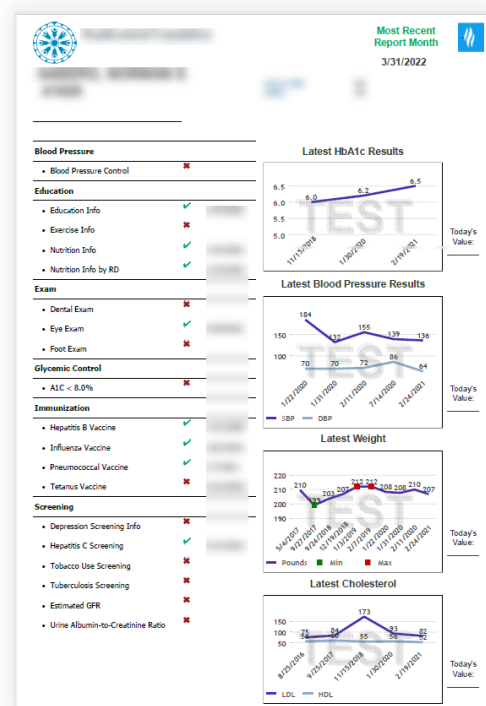
Check out the Patient Handout Feature of the Dashboard!

Would you like to have a tool that would automatically create a patient education handout specific to the patient you are talking to during a clinic visit? The handout would have the person's recent history of A1cs, blood pressure readings, LDL cholesterol, weight and more? It would let that person know the date of their last foot exam, or any other diabetes standards of care, but only if you want? In fact, by just selecting measure groups (like checking boxes), you would determine what information is featured in the handout and what is left off?

Does this sound like an awesome tool that you need to get your hands on? Well you are in luck. You have access to this tool already. The patient handout is just ONE of MANY cool tools that you can find in the ANTHC SDPI Diabetes Dashboard, but it is definitely one of the favorites of the ANTHC diabetes educators.

The ANTHC Special Diabetes Program for Indians (SDPI) Diabetes dashboard is a tool that is available for Alaska tribal health providers and program staff. If you are unfamiliar with the dashboard, or to learn more about how to access the patient handout feature, please contact mnarayanan@anthc.org for orientation and training.

This is a picture of the patient handout if all the boxes are checked. You could also decide just to feature one or two items, if that would be a better format for the patient you are talking to and what you covered during your visit that day.

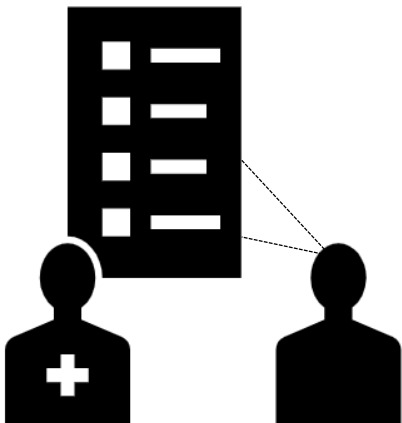


When Does a Person *Officially* have Diabetes?

Can diabetes be difficult to diagnose? Not with routine blood tests. There are very specific guidelines and criteria for diagnosing diabetes. You can see what those guidelines are in the table below. Even though diabetes is not difficult to diagnose, many people live with diabetes for years before they are diagnosed.

This happens for two reasons:

- 1) Many people may not get routine blood tests, so their provider may not know when a person’s blood sugar becomes elevated.
- 2) Many people believe they will have signs or symptoms that will alert them if they have diabetes.



However, the early stages of diabetes typically have NO or very few symptoms. In fact, many people have diabetes for years without knowing they have it. Do the people in your community know how and where to get screened for diabetes? Many SDPI Programs around Alaska include activities for helping community members find out if they have prediabetes or diabetes. If you are interested in including screening activities as part of your local SDPI program, make sure to bring it up with your fellow SDPI coordinators. You are sure to hear some great ideas about what’s happening around the state.

A screen capture of the American Diabetes Association diagnostic criteria for Diabetes Mellitus is seen below. Two values meeting diagnostic criteria are required unless a patient has classic symptoms or a random glucose ≥ 200 mg/dl as explained below.

Table 2.2—Criteria for the diagnosis of diabetes FPG ≥ 126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.*
OR
2-h PG ≥ 200 mg/dL (11.1 mmol/L) during OGTT. The test should be performed as described by WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*
OR
A1C $\geq 6.5\%$ (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.*
OR
In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 200 mg/dL (11.1 mmol/L).
DCCT, Diabetes Control and Complications Trial; FPG, fasting plasma glucose; OGTT, oral glucose tolerance test; WHO, World Health Organization; 2-h PG, 2-h plasma glucose. *In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Source: https://diabetesjournals.org/care/article-pdf/44/Supplement_1/S15/S51701/dc21s002.pdf; Page 3; Classification and Diagnosis of Diabetes; Accessed online 3/1/2022

Holding a Community Data Walk!

A Data What? A Data Walk is a way of sharing data with communities, but it's also a tool for collaboration and community engagement.

Data Walks consist of a public room or space with interactive stations. Each station contains one piece of data with a simple, easy to understand graph or finding that informs community members of something happening in their community. The data should include the source. Each station should have a facilitator present that listens to community members thoughts on that particular piece of data, answers questions the participants have, and

listens to ideas about the programming or local resources community members feel would best address the data being shared. Data Walks are about ALL stakeholders (programs, community members, community organizations) sharing, analyzing and making use of data jointly. It ensures community members are actively involved in community programming.

A Data Walk has a few objectives:

- 1) Share data with the community stakeholders to empower and inform community members.
- 2) Get feedback on the data.
- 3) Learn more about the types of programming and practices community members would like to see address community needs.
- 4) Learn more about the community perspective on local resources.
- 5) Inspire individual and collective action.





Things to do to ensure a successful Data Walk in your community:

- 1) Who will you invite?
Talk to community leaders, faith-based leaders and other people from the community that can help you get the word out about your event. Recruit participants with diverse perspectives.
- 2) Offer activities for children.
- 3) Offer food.
- 4) Make sure there are translators present or that there are people at each station that are bilingual.
- 5) Create a safe place. The idea is to shift the power from the health professionals to the community members. What are good places in your community for something like this?
- 6) Make the first station a community mapping exercise. Allow community members to tell YOU about local resources (individuals, organizations, nature, etc.). What do people see as community strengths?
- 7) Make sure the data is accurate, simple, and easy to understand. Each station should make only ONE point.
- 8) The people at each station should be able to answer questions and facilitate discussion. They should also be aware of resources, should an individual ask.
- 9) Make each station as interactive as possible.
- 10) You can use Facebook Live or Instagram to include virtual audiences. People can comment publicly or message privately to comment.
- 11) Make the last station a visioning exercise. “What does *better* look like to you?” You can use butcher paper and different colored sticky notes with pictures or words drawn by community members.



The Diabetes Registry Origin Story

An Interview with Cindy Schraer, MD, Founder of the ANTHC Diabetes Program

Can you tell me what your job was when the Alaska statewide registry was started?

It was 1985, and I was working as a teacher for the health aide program and also as a primary care provider at ANMC. I was assigned to update the diabetes section of the Health Aide Manual. I didn't know much about diabetes at that time, and I was curious. The belief at that time in the healthcare world was that Alaska Native people didn't get diabetes. I worked as a primary care physician in Barrow from 1975-1978, and it was true that I had almost no patients with diabetes. However, when I moved to Anchorage I did start to see some patients who developed the condition. I wondered about the cause. Was it a change in lifestyle? Were the low rates in Barrow specific to being Inupiaq? I didn't know. I wanted to learn more about what was happening with diabetes among Alaska Native people.

About this time, I was asked to attend a meeting where the head of the Indian Health Service Diabetes Program was talking about the devastation of diabetes in the lower 48, but noted that the available Indian Health Service data showed that Alaska Native

people didn't have much diabetes. I wondered if that was true, as I had several patients with diabetes. I used the electronic health system at that time (much different than the electronic health records we have now), and found hundreds of people that had diabetes visits. But when I shared this information, the rest of the healthcare team believed those numbers were likely due to tourists and the Coast Guard. At first glance there was no way of knowing if those diabetes visits were from Alaska Native people or non-beneficiaries. Previously, Martha Wilson, the Anchorage Service Unit Director, had realized we needed to have a computer-based records system, and that registries were vital to management of some health conditions. We needed an accurate count of Alaska Native people with diabetes, and we needed to make sure people with diabetes weren't falling off the radar. So several of us worked with CDC to establish a diabetes registry.

Since the registry wasn't part of my job at the time, I started working on it at home in the evenings. Eventually the Area Diabetes Coordinator position was developed, and I

was asked to take the job, since I had an interest in diabetes and had been doing so much work in the area.

Were any other IHS areas starting registries?

No. Some places had patient lists, but not formalized registries. The lower 48 areas were overwhelmed with providing diabetes care. They had lots of people with diabetes on dialysis and suffering amputations and the ability to develop registries just wasn't there.

How did you envision the registry would be used by in Alaska?

There were three main functions I wanted the registry used for: First, I wanted the registry to be used to improve patient care. Better tracking means people wouldn't be lost to follow up and would get their needed diabetes care appointments. Second, I knew we needed an accurate count of people with diabetes, so we understood the problem. Lastly, we needed funding to care for the growing number of people who were developing diabetes and for diabetes prevention efforts, and having data is an important part of getting funding.

Are you surprised the registry is still running strong in 2022?

In a way, yes. It takes a lot of work to maintain a registry. In a way no, because it's the basis for clinical care and reducing complications. It keeps patients from being lost to follow up. It's necessary.

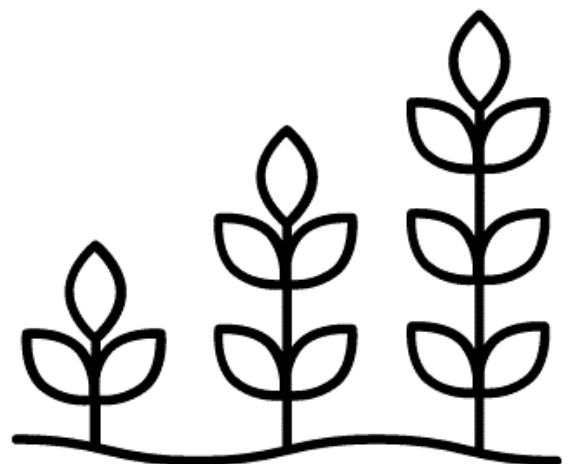
What do you credit the longevity of the registry to?

There are two things that keep the registry going. One, there have been people that have showed up over time that have been

interested in keeping it going. Two, there is a need for a registry. Even when we saw increasing rates, we could see that diabetes was still a problem we could do something about. In the beginning when we started tracking the situation, diabetes and its complications were not evenly distributed. In some areas of the state, people had a lot of amputations; in other areas more people had renal failure. It gave a picture of where and how health professionals involved in the health care of Native people could focus efforts.

Anything else you want people to know about the Alaska Area diabetes registry?

The diabetes registry has adapted over time to changes in technology and changes in staffing, and it continues to adapt and change. The registry is never a result of one person's efforts. It takes support of so many people to understand the importance of electronic record keeping, data and tracking of people. The people that have made the registry happen go back 37 years, to now including all the coordinators and the people involved from an Information Technology standpoint. It really is a statewide team effort.





ANTHC Diabetes Program
 Healthy Communities Building
 3900 Ambassador Drive
 Anchorage, 99508

mnarayanan@anthc.org

anthc.org/what-we-do/wellness/diabetes-patients-providers